encourage colleagues to report use of the drug for all to benefit. We share the authors concern on the lack of an effective system of drug regulation and monitoring. The burden of regulation and off label use of drugs rests with the state and the laws of the land, as much as with the conscience of the practising physician. However we agree that there should be some regulation to check and ensure safety of newborn care, our article clearly discourages the use of sildenafil by the individual practitioner other than in a research setting.

M Malik and R Nagpal
m.malik@maxhealthcare.com

Infant and Young Child Feeding Guidelines: 2010

We have following comments to submit in respect of the Infant and Young Child Feeding Guidelines: 2010 published in *Indian Pediatrics* [1].

1. While discussing HIV and infant feeding, the guidelines mention use of expressed, heat-treated breast milk as one of the alternatives to breastfeeding in infants less than six months of age. Guidelines need to mention a standardized method of heat-treatment of breast milk which should be fulfilling AFASS criteria. It should be borne in mind that it may not be possible to use a thermometer in a domestic setting to decide about the temperature to which the expressed breast milk should be heated.

2. While discussing HIV and infant feeding, the guidelines also mention introducing appropriate complementary foods after 6 months of life and continuing breast feeding for the first 12 months of life. This amounts to mixed feeding for second six months of life. In the same section, towards the end, the guidelines mention that mixed feeding should be avoided (except the short transition period of around a month when breast-feeding is being gradually stopped) as it causes a two fold increase in the risk of postnatal HIV transmission. This contradiction needs to be resolved.

DALJIT SINGH AND R GHULIANI,
Department of Pediatrics,
Command Hospital (SC),
Pune 411040, MS, India.
maapavitra@gmail.com

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REPLY

1. Methods such as Pretoria Pasteurization or Flash Heat Treatment can effectively inactivate the virus in breastmilk from HIV-infected mothers [1,2]. These methods can also eliminate potential contaminants and adequately inhibit bacterial growth while retaining nutrients contained in breastmilk [3]. In a developing country set up where thermometer may not be available everywhere, it may be difficult to mention a standardized method, but breastmilk treated in this way is nutritionally adequate to support normal growth and development. However, it is difficult to sustain adhering to this method over a prolonged duration. The role of heat treatment as a truly feasible HIV prevention and child survival strategy is yet not clear [4]. However, this approach (heating to the boiling point) is useful as an 'interim' strategy to assist mothers over specific periods of time.

2. The term "Mixed feeding" is generally referred to feeding of breastmilk and other liquid/solids food prior to 6 months of age. It is hypothesized that when these infants are mix fed, the immature gastrointestinal tract is exposed to antigens and pathogens which may cause inflammation and facilitate acquisition of HIV infection [5] Exclusive breastfeeding may be healthier because it protects the integrity of the intestinal mucosa, a barrier to HIV. Another possible mechanism is that mixed feeding results in suboptimal breastfeeding practices which predisposes to mastitis and cracked nipples, consequently increasing the risk of transmission.

After six months the gut is more mature and better able to handle complex proteins and antigens significantly decreasing the risk of transmission. Thus after six months of age, the nutritional benefits of complementary feeding (which may or may not be milk based) and extended breastfeeding till 12 months outweigh the risk of transmission and is probably the best possible strategy for HIV-free survival. This is all the more true if the mother and baby are on antiretroviral prophylaxis or therapy as the